PUBLIC REPORT
(PURSUANT TO INSURANCE CODE SECTION 12938)

OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY

NAIC # 70785 CDI # 3086-6

AS OF JUNE 30, 2006

[Made available in accordance with CIC Section 12938)]

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

Format 12938

NOTICE REGARDING CONFIDENTIALITY

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. Section 12938 of the California Insurance Code requires the publication of certain legal documents and examination reports.

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DEPARTMENT OF INSURANCE
Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

January 18, 2008

The Honorable Steve Poizner
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims practices and procedures in California of:

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY

NAIC #70785

Hereinafter, the Company listed above also will be referred to as PacifiCare or the Company.

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

FOREWORD

The examination covered the claims handling practices and policy terminations of the aforementioned Company during the period July 1, 2005, through June 30, 2006. The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. The alleged violations of other relevant laws which resulted from this examination are included in a separate report.

The report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer's proposals for correcting the deficiencies. When a violation that resulted in an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company's responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.

3. A review of consumer complaints received by the California Department of Insurance (CDI) in the most recent year prior to the start of the examination.

The sample of individual claims files reviewed was conducted at the offices of the Company in Cypress, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The files reviewed were closed between July 1, 2005 and June 30, 2006, referred to as the "review period". The examiners randomly selected 297 PacifiCare files for examination. The examiners cited 40 alleged claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 from this sample file review.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY			
LINE OF BUSINESS/CATEGORY	**FILES FOR REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**CITATIONS**
Group Dental PPO	64,141	68	25
Health-Indemnity Group	9,150	68	12
Health-PPO Group	1,246,766	68	1
Health-PPO Individual	41,384	68	2
Policy Terminations	25	25	0
TOTALS	1,361,466	297	40

TABLE OF TOTAL CITATIONS

Citation	Description	# CITATIONS
CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	9
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.	9
CCR §2695.11(b)	The Company failed to provide an explanation of benefits.	9
CCR §2695.3(a)	The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim.	3
CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.	3
CCR §2695.5(a)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days.	2
CCR §2695.5(e)(3)	The Company failed to begin investigation of the claim within 15 calendar days.	2
CCR §2695.11(a)(2)(c)	The Company improperly sought reimbursement of an overpayment beyond 6 months of the initial payment	1
CCR §2695.4(a)	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	1
CCR §2695.5(e)(1)	The Company failed to acknowledge notice of claim within 15 calendar days.	1
Total Citations		40

TABLE OF CITATIONS BY LINE OF BUSINESS

GROUP DENTAL PPO	NUMBER OF CITATIONS
CCR §2695.7(g)	9
CIC §790.03(h)(3)	7
CCR §2695.11(b)	6
CCR §2695.3(a)	1
CCR §2695.5(a)	1
CCR §2695.5(e)(3)	1
SUBTOTAL	**25**

HEALTH-INDEMNITY GROUP	NUMBER OF CITATIONS
CIC §790.03(h)(1)	3
CCR §2695.3(a)	2
CIC §790.03(h)(3)	2
CCR §2695.11(b)	1
CCR §2695.7(g)	1
CCR §2695.5(e)(3)	1
CCR §2695.11(a)(2)(c)	1
CCR §2695.5(e)(1)	1
SUBTOTAL	**12**

HEALTH-PPO GROUP	NUMBER OF CITATIONS
CCR §2695.11(b)	1
SUBTOTAL	**1**

HEALTH-PPO INDIVIDUAL	NUMBER OF CITATIONS
CCR §2695.5(a)	1
CCR §2695.4(a)	1
SUBTOTAL	**2**

TERMINATIONS	NUMBER OF CITATIONS
	0
SUBTOTAL	**0**

TOTAL	40

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved. Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked to take appropriate corrective action in all jurisdictions where applicable. Money recovered within the scope of this report was $471.46. Pursuant to the findings of the examination referenced below in number 1B, the Company conducted a closed claim survey resulting in additional payments of $30,000. As a result of the examination, the total amount of money returned to claimants within the scope of this report was $30,471.46.

GROUP DENTAL PPO

1. In nine instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.

A. The Company automatically defaults dental Preferred Provider Organization (PPO) fee out-of-network claims to Region 1 (Los Angeles/Orange County) rates on some dental policies. In these policies, the Company separates the state into five regions where scheduled reimbursement levels are higher for providers in regions three thru five than regions one and two. The Certificate of Coverage page six, number seven, defines a covered expense: "for Non-Participating Providers, does not exceed the lesser of billed charges and the scheduled fee or Usual and Customary Charges". Page ten of the Certificate of Coverage defines a Usual and Customary charge as: "1) A Provider's usual charge for furnishing treatment, service or a supply; or 2) the charge the Company determines to be the general rate charged by others who render or furnish such treatment, services or supplies to persons who reside in the same geographic area and whose Accidental Injury or Sickness is comparable in nature and severity." When customers in regions three thru five receive treatment out of network their providers are paid a percentage of the scheduled benefit based on Region 1 rates of reimbursement. When the Company defaults to Region 1 pricing they are not basing reimbursements on the actual scheduled fee in effect for in-network providers in regions three thru five. Further, the Company is not adhering to their definition of usual and customary charges.

B. In one instance, an erroneous procedure code of D7110 was used. The Company indicates the correct procedure code should have been D7140 which has an allowable amount of $68.00. As a result of the examination findings, a check was issued to the claimant for $16.80 which was the difference that was owed. In one instance, the Company was still utilizing the old 2004 rates for Procedure D1201 under Region 1 for 2005. The Company only paid an allowable amount of $66.00. As a result of the examination findings, a check was issued to the claimant for $11.00 which was the difference that was owed.

The Department alleges these acts are in violation of CCR §2695.7(g).

Summary of Company Response:

A. The Company reviewed the instances where the Department alleges that the Company attempted to settle a claim by making a settlement offer that was unreasonably low and respectfully disagrees with the Department's allegations. All instances were paid in accordance with the set fee schedule for out of network providers. However, the Company does believe the application of the set fee schedule is not clearly stated in the Certificate of Coverage. To address this issue, the Company will take the following corrective action:

- File an amendment to the Certificate of Coverage to clearly define a covered expense for Non-Participating Providers as the lesser of billed charges or a scheduled fee for Usual and Customary Charges by 1/31/2008.
- Include the out-of-network fee schedule as part of the amendment to the Certificate of Coverage.
- Mail the amended Certificate of Coverage and out-of-network fee schedule to all PPO membership in California by 2/29/2008

B. A data keying error when updating the Fee Schedule for 2005 has been identified as the reason for the discrepancy with the eligible expense and fee rate schedule. The Company conducted a self-review for all claims using procedure codes D0272 or D1201 and D7110 or D7140 for dates of service January 1, 2005 through August 30, 2006. Additional monies owed plus applicable interest was processed totaling $30,000. Further, the fees will update in the computer system to reflect the correct dollar amount as indicated on the rate schedule for future claims processing.

Item 1A is an unresolved issue and may result in administrative action.

2. In seven instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.
The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company utilizes an outdated Health Insurance Association of America (HIAA) schedule to pay out-of-network claims under its Preferred Provider Organization – Usual Customary Reasonable (PPO-UCR) dental PPO plan. The Company has no system, policy or procedure in place to update its claims paying system to the most current and applicable dental rates in line with industry standards and practices. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of Company Response: The HIAA schedule used for claims processed in the window period July 1, 2005-June 30, 2006 was in accordance with the benefit structures for the associated members. The Company updated its UCR schedule in 2003 to the 2000 version of HIAA table of allowance. The Company's reimbursement methodology for services rendered by non-contracted providers is based on statistically credible information purchased from Ingenix. The prevailing health care charges data is reviewed annually to determine if an update to the

reimbursement schedule is necessary in order to remain fair and equitable in the settlement of claims as required under the California Insurance Code for standards of prompt, fair and equitable settlements. Our review includes such factors as: the magnitude and relative impact of allowable charges; location of members and associated impacts; member utilization by procedure code; and the percentile level being used to determine the allowable rate. If for example, we change to a new version of the schedule, we might also change the percentile level used to determine allowable rate in order to maintain appropriate benefit cost ratios. Although the Company utilizes a prior year HIAA schedule for UCR determination, we believe that reimbursements offered are not unreasonably low and are within a fair and equitable range of settlement.

This is an unresolved issue and may result in administrative action.

3. In six instances, the Company failed to provide to the claimant an explanation of benefits including the name of the provider or services covered dates of service, and a clear explanation of the computation of benefits. The Company did not provide complete breakdown, disclosure and information about the ineligibility of this charge on its Explanation of Benefit (EOB). The specific American Dental Association (ADA) procedure code "200" has been modified by the Company to D7110 without any clear explanation. The Department alleges these acts are in violation of CCR §2695.11(b).

Summary of Company Response: The Company acknowledges the findings and states the issue has been reported to its computer technology staff (IT) to research and determine a resolution for extracting the appropriate explanation code to print on the EOB for frequency limitations when processing x-rays. Further, in the instances noted, the Company corrected the EOB.

4. In one instance each, the Company failed to comply with the following sections of the Fair Claims Settlement Practices Regulations. In one instance each, the Company failed to comply with the following: CCR§ 2695.3(a), CCR§ 2695.5(a), and CCR§ 2695.5(e)(3). The Department alleges these acts are in violation of the Fair Claims Settlement Practices Regulations.

Summary of Company Response: The Company acknowledges the above instances. The Company maintains these are isolated instances and not reflective of the Company's standard claims handling procedures in place at the time of the exam.

HEALTH-INDEMNITY GROUP

5. In three instances, the Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. In one instance, a system generated remark code found on the EOB states that "Claims and Claims Procedures for Insurance" are found in Section 10 of the Certificate of Coverage. This is not correct, the information is found in Section 2 of the Certificate of Coverage. In one instance, a system generated remark code found on the EOB states that "Definitions" are found in Section 4 of the Certificate of Coverage. This is not correct, the information is found in Section 5 of the

Certificate of Coverage. In one instance, a claim was processed with a system generated remark code that said, "The plan only allows 20% of Medicare's approved amount." This is an error and the remark code should have said, "This amount represents PacifiCare Network discount." The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of Company Response: The Company agrees that it failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to coverage at issue. The Company implemented revised EOB remark codes in October 2007 and conducted training on proper remark code usage The Company acknowledges the above instances.

6. In two instances, the Company failed to maintain all documents, notes and work papers in the claim file. In one instance, the Company denied a claim because of a prior request for information was made. However, there is no documentation in the file to support this request was made. In one instance, a denied bill for medical treatment was not in the claim file and was not produced by the Company from archives for examiner review. The Department alleges these acts are in violation of CCR §2695.3(a).

Summary of Company Response: The Company acknowledges that it failed to maintain claim file documentation in the two instances noted. The Company conducted additional training in October 2007 to address the Fair Claims Settlement Practices including the specific requirements for properly documenting a claim adjudication decision.

7. In two instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. In one instance, there was a gap in file activity between 5/23/05 and 7/6/05. In one instance, the Company denied a claim as falling within the pre-existing period. The proof of creditable coverage received clearly indicates the prior coverage was Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA eligibility is only available when prior medical coverage has been provided thru an employer. The Company failed to investigate coverage prior to COBRA. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of Company Response: The Company acknowledges the processing gap and investigation oversight. These instances have been identified as training issues and will be addressed accordingly with staff.

8. In one instance, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. The claim was processed for one charge when the billing indicated there were four separate charges totaling $802.64. The claim was reprocessed for the additional three charges and paid with interest. As a result of the examination findings, a check was issued to the claimant for $443.66. The Department alleges this act is in violation of CCR§ 2695.7(g).

Summary of Company Response: The Company acknowledges the above instance and reprocessed the claim with interest.

9. In one instance, the Company sought reimbursement of an overpayment more than six months from the date of error. The Company sought reimbursement for a claims overpayment more than six months from the date of the erroneous payment. The original claim was processed 8/1/05 indicating on the Explanation of Payment (EOP) benefits were coordinated with Medicare. The physician advised that Medicare paid as primary on 5/12/06. A request for reimbursement from the provider was made by the Company on 6/20/06. The Department alleges this act is in violation of CCR§ 2695.11(a)(2)(c).

Summary of Company Response: The Company respectfully disagrees with the Department's conclusion that it violated CCR Section 2695.11(a)(2)(C) in the referenced instance. The provider filed the claim and was paid by the Company on 8/1/05. On 5/12/06, the provider notified the Company that the claim was paid in error because the provider had filed the claim to the Company as the primary when in fact Medicare was the primary payer. The provider was responsible for the error and notified the Company of the error on 5/12/06, the Company then, at the provider's request, issued a request for reimbursement to the provider on 6/20/06. In this instance, pursuant to the language of CCR 2695.11(a)(2)(C), the date of the error was 5/12/06 since the error was the result of a misrepresentation of the provider in the filing of the original claim. The fifteen day notice requirement of CCR 2695.11(a)(2)(C) was fulfilled since the provider was the one who identified and notified the Company of the error and requested the request for reimbursement be issued by the Company.

This is an unresolved issue and may result in further administrative action.

10. In one instance each, the Company failed to comply with the following sections of the Fair Claims Settlement Practices Regulations. In one instance, each the Company failed to comply with the following: CCR§ 2695.5(e)(2), CCR §2695.11(b), and CCR§ 2695.5(e)(3). The Department alleges these acts are in violation of the Fair Claims Settlement Practices Regulations.

Summary of Company Response: The Company acknowledges the above instances. The Company states these are isolated instances and not reflective of the Company's standard claims handling procedures in place at the time of the exam.

HEALTH-PPO GROUP

11. In one instance, the Company failed to provide to the claimant an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits. The Company's EOB is non-specific as to which maximum limit of the policy was applied. The EOB does not include a clear explanation of benefits denied. The Department alleges these acts are in violation of CCR §2695.11(b).

Summary of Company Response: The Company agrees that it failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. The Company implemented revised EOB remark codes in October 2007 and conducted training on proper remark code usage.

HEALTH-PPO INDIVIDUAL

12. In one instance each, the Company failed to comply with the following sections of the Fair Claims Settlement Practices Regulations. In one instance each, the Company failed to comply with the following: CCR §2695.5(a) and CCR§ 2695.4(a). The Department alleges these acts are in violation of the Fair Claims Settlement Practices Regulations.

Summary of Company Response: The Company acknowledges the above instances. The Company maintains these are isolated instances and not reflective of the Company's standard claims handling procedures in place at the time of the exam.

TERMINATIONS

There were no citations alleged or criticisms of insurer practices in this line of business within the scope of this report.